PRINTED: 01/29/2015 FORM APPROVED

Indiana State Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE MEADOWS CX4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) R 000 INITIAL COMMENTS R 000 INITIAL COMMENTS R 000 C C 01/22/2015 B. WING COMPLET (EACH CORRECTION OF CORRECTION SHOULD BE COMPLET ATM OF CORRECTION SHOULD BE COMPLET ATM OF C	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) R 000 INITIAL COMMENTS STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE R 000 INITIAL COMMENTS R 000			000529	B. WING		1		
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be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed 1-26-15 by Brenda Marshall, RN.	R 000	X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) R 000 INITIAL COMMENTS Zionsville Meadows Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed 1-26-15 by Brenda		R 000	DEFICIENCY)			

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE